

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **PROVIDER AGENCY MEDICAL DIRECTOR NOTIFICATION  
OF CONTROLLED SUBSTANCE PROGRAM  
IMPLEMENTATION**

REFERENCE NO. 702.4

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I \_\_\_\_\_ am a physician licensed by the State of California to practice medicine, and authorized by the U.S. Department of Justice - Drug Enforcement Administration to purchase schedule II - IV controlled substances. My DEA registration number is \_\_\_\_\_. I have current knowledge of all Federal, State and County Regulations governing controlled substance procurement and administration and will assume total responsibility for the controlled substance "program" at \_\_\_\_\_, Fire Department/Approved ALS Provider Agency, including but not limited to, procurement, storage, control, safeguards, recordkeeping, disposal, and inventory.

Physician

Fire Chief/CEO/President

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date